ARMED FORCES INSTITUTE OF PATHOLOGY
ORAL HISTORY PROGRAM

SUBJECT: Dr. Sharon W. Weiss
INTERVIEWER: Charles Stuart Kennedy
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Q: Dr., I wonder if you could give me a bit about your background, when and where you were born and a bit about what kind of a family you came from and how you got educated.

DR. WEISS: I was born outside Boston, in a town called Lynn. My father was an Army surgeon, and as a result, we were a very peripatetic family although I always considered myself a New Englander and someone who would ultimately return to the Northeast. Those dreams will probably never be realized. We were stationed in Valley Forge, Pennsylvania, Munich, Germany, Washington, D.C. and Honolulu, Hawaii.

However, when I decided to pick a college, I did pick a Northeastern college. I went to Wellesley College, outside Boston. I picked Wellesley because at that time if one was a woman and wanted to go to a very good college, options like Harvard, Yale, and Princeton were not available to women, so I picked one of the Seven-Sister schools. I chose Wellesley because of its proximity to Boston and, quite frankly, because it had a beautiful campus.

Q: It does have a beautiful campus.

DR. WEISS: Lake Waban is absolutely gorgeous. I was married shortly after graduating from Wellesley.

Q: What were you studying there?

DR. WEISS: I was a biology major there. It was shortly after they combined the zoology department and the botany department into biology. Of course molecular biology was a thing of the future; it was rather traditional biology at that time. But it was a wonderful experience because you were really in a situation where, as I'm sure you've heard before, women were encouraged to do anything and everything. We had women who were president of the college government, and head of the yearbook. So women were just encouraged to do as much with themselves and their talents as possible. There were no limitations placed on women in an environment like that. I have a daughter who's now at Wellesley. She tells the story differently now; I guess times have changed. Be that as it may, it was a good four years.

I was married about three months after graduating, and I took a year off to be with my husband, who at that time was a post-doctoral fellow at Harvard Medical School, working in the biochemistry department. I worked as a laboratory technician in the

Department of Anatomy at Harvard--Don Fawcett's department, which was, I think, a fairly well-known department by virtue of its chairman--with plans to go to medical school the following year.

Fortunately, my husband and I both found positions at Johns Hopkins. He went there to be junior faculty member in microbiology, and I went as a medical student. I spent nine really wonderful years at Johns Hopkins, first as a medical student, then as an intern and a resident, and then finally one year as an assistant professor in the pathology department before coming to the Institute.

Q: Was your specialty pretty well cut out for you at the time? Did you get a medical degree, or was it a biology degree?

DR. WEISS: I got an A.B. in biology from Wellesley, and then and M.D. from Johns Hopkins. Of course, one doesn't subspecialize as an M.D.; it's just fairly standard courses. But I knew very early in medical school that I wanted to be a pathologist. I think it partly had to do with my father. Although he was a surgeon, he liked pathology very much, and always said, "Surgeons need good surgical pathologists." And I suppose I thought that somehow being a surgical pathologist was something very special. I still feel that way, but maybe for different reasons than my father thought so. So I decided, really when I was a second-year medical student, that I was going to be a pathologist, and by my third year in medical school, I knew I wanted to be a surgical pathologist. I began to differentiate, if you will, very early, and really never wavered very much from my intentions.

Q: I'm speaking as a non-medical person doing this, but with pathology and surgical pathology, did you find any people with those words of wisdom that you get in any graduate school that you're going to, such as, "Oh, you want to go into this field, and that field. Oh, the money's here, the money's not there. This is tough, that's not"? What sort of directions were you getting from your fellow students and those somewhat ahead of you?

DR. WEISS: I think the most common remark, or the most prevalent idea, was: "You like people too much, how could you want to be a pathologist? Pathologists don't like people; they're introverts." And I had a great deal of pressure placed on me to go into internal medicine. Internal medicine at Johns Hopkins was really considered the most illustrious department steeped in the tradition of William Osler. To get an Osler internship was considered the pinnacle of success, and I was told that if I wanted an Osler internship I could have one, and how could I possibly not want to do that? Quite frankly, I wanted to be a pathologist. But there was really quite a prevalent attitude that pathologists don't interact well with other people, they don't like people, they're very reclusive, and if one has any sort of extroverted tendencies, one clearly had to be a surgeon, internist, or pediatrician, I suppose, if you're a woman, really internal medicine or pediatrics.

Q: I'd like to touch on this mainly because of the spirit of the times, but was pathology, we're talking about the early times, was this considered a field women went into, or were there inhibitions about going into it, or was it considered, like pediatrics, something, gee, it's a good idea to go into?

DR. WEISS: Yes, I think there was an element of it's a good idea to go into, because one can structure one's life better if one is in pathology. So I suppose there was an element of pragmatism in my decision, but I can honestly say that it was a minor consideration, that I truly enjoyed the discipline. I felt that it cut across all disciplines. It was, after all, the study of disease--disease whether it's in a surgical patient or a medical patient or a young child. I thought it really sort of provided a marriage of the clinical sciences and the basic sciences, and in that respect, it cross-linked a lot of things in medicine for me. I had a very charismatic teacher at Johns Hopkins, a surgical pathologist anmed Dr. William Shelley, and he influenced me as well.

Q: Was your father still alive?

DR. WEISS: Oh, yes.

Q: Was he sort of saying, "Go for it."?

DR. WEISS: Yes, he approved, because, as I told you, he liked pathology himself. My father does not brag, he is a fairly modest man, but in one of his little slips of immodesty, he did tell me once that he got the highest grade in the entire country on the National Boards in Pathology when he was a medical student at Yale. And from that time on, he always considered himself an amateur pathologist. No matter how good a pathologist he had in his hospital, he would always go and look at his slides. So I think this had a lot to do with just hearing the word and being aware of what pathologists did, from a very early age.

Q: And in a very positive sense.

DR. WEISS: And in a very, very positive way. So I think my father sort of told me what pathology was about, I discovered I liked it very much in medical school, and then I had some impressive role models, some very wonderful people that I still look back on with a great deal of fondness.

Q: Before 1976, were you specializing in a field of pathology more or less, or were you still a fairly well-rounded pathologist?

DR. WEISS: I would say I was a well-rounded pathologist; I had no area of expertise. And that was really my reason for going to the AFIP. I felt that although we like to think

that the day of the renaissance man (or woman) may still be with us, in fact it's impossible to know everything, it's impossible to be good at everything, and so one is really valued for one's expertise in a more focused area. And I felt that at the AFIP I could focus. I think I had a strong background up until that time, but I realized that to really achieve and to accomplish anything, one was going to have to focus one's energy in a narrower fashion. So I came to the AFIP undifferentiated and unfocused, but willing to make the commitment to focus a little bit more.

Q: Obviously, you were an Army brat, so that the AFIP and the military was not unknown territory to you, but what was your impression of its utility and how it was run and all, before you went there and when you were making up your mind?

DR. WEISS: I think I knew the AFIP by virtue of the fact that it put out this wonderful set of fascicles. These were books that were written by various experts. The first series of fascicles that I ever saw were bound in sort of a very bland-looking grey paper, very unpretentious, but they probably did more to disseminate information about the AFIP than anything else. They were very cheap and affordable by Third-World countries and by residents. So I thought of the AFIP in terms of the fascicles they put out.

I also thought about the AFIP in terms of the slide sets that they put out. They are a wonderful repository of slide sets on various organ systems and disease processes, which they would loan you free of charge. You, of course, had to send them back in two weeks, three weeks. I can remember being sick at some time during my residency (I can't remember quite the circumstances), and I was at home with my microscope, but I remember spending those three or four weeks that I was sick looking through slide sets that the AFIP had. And they had a little syllabus that came with them that annotated the various cases.

So I guess my first exposure was that it was very strong in terms of educating the public in pathology. By "public" I don't mean the general public, but pathologists throughout the country and throughout the world. I really didn't know anyone at the AFIP except by publications.

Q: How did you happen to go to the AFIP?

DR. WEISS: I had thought about going to the AFIP right after my residency and taking a two-year fellowship. I never really thought about going there for a long time. I guess at the same time I thought it was good to specialize, and I also thought it was good not to lose one's ties to a hospital, to the patient, and to the kind of information that accrues to you as a result of being in a hospital. So I had intended to go just for two years. This would have been back in 1975. At the same time Johns Hopkins offered me a staff position. I guess I felt that since I was living in Baltimore, and I had a family, and with that commute and so forth, it would be better to take the job at Johns Hopkins. I guess in some ways I regretted that decision, because a year later I reconsidered the decision. I think there were some things about my job at Hopkins that left me a little bit unsatisfied,

and so I sort of reapplied the following year. Fortunately, there was a position, and so I went a year later, having made the decision not to go there the previous year. Things worked out very well, and I stayed for thirteen years, a very long fellowship!

Q: Did you have any feel about how they screened applicants for these positions?

DR. WEISS: Darned if I know. It was the strangest thing. It wasn't like applying for a residency or medical school, where there were forms to fill out and there were deadlines and you sent a check in and you heard by a certain date. It seemed to be very loosely constructed. I called Dr. Enzinger, who at that time was chairman of the soft-tissue branch, and asked him if I could come work there. He said, "Sure, why not?"

I didn't know if that was an acceptance, or if that was an invitation for an interview, so I said, "Well, I guess you'll probably want to interview me."

And he said, "Yes, if you want."

This was also very relaxed. I finally did go there for an interview, and I went down to see Dr. Enzinger, and he said it would be fine with him if I came.

And then I went to Dr. Helwig. I think Dr. Helwig is still at the AFIP.

Q: He's only part-time.

DR. WEISS: And I told him that I wanted to go and work in the soft-tissue branch with Dr. Enzinger. And he said, "Well, I just don't know if we can do that."

And I said, "Well, what do you mean? Why can't we do this?"

He said, "Well, you know, it depends on whether he wants you, and whether there's a position, and other departments."

And I said, "Well, Dr. Helwig, it seems very simple to me. I want to go work for Dr. Enzinger, and he has said that he wants me to come, and there is a position. Isn't this a match?"

"No, no, it's very complicated."

And I didn't really understand all of this. Well, I later was told that the way it worked was Dr. Helwig often siphoned-off people first before he'd send them to other branches, and so he sort of screened people, deciding whether he wanted to keep them in his own branch. And therefore he was unwilling to make a commitment on the spot.

And I said to him, as diplomatically as I could, "Well, Dr. Helwig, I just want you to know that my application is really not to come to the AFIP at large, but it's really to go to the soft-tissue branch and work with Dr. Enzinger. So if you can't see your way to assign me there, then I don't think I'll be coming at all." I let him know this very politely. And, fortunately, I think that, plus whatever Dr. Enzinger said, was enough to create the match.

But it was a very casual sort of way of applying.

Q: But obviously, although it was casual, there was also purpose; everybody knew what they were doing.

DR. WEISS: Oh, yes, everyone had their own agenda. But I walked in like a pollyanna, really not understanding where Dr. Helwig was coming from. Of course, I understood Dr. Enzinger: he had someone who wanted to come work for him, he had a slot, he needed someone, so it was fine with him.

Q: What were the concerns of the soft-tissue branch in 1976, and what you were particularly interested in?

DR. WEISS: I think the soft-tissue branch, and all the other branches, for that matter, served as reference centers for difficult and complicated cases in a particular area. You have to remember that the network of consultants that exists now in this country did not exist when the AFIP opened, which was in the late forties or early fifties. The AFIP really was unique in that it represented a collection (I shouldn't say "collection," it sounds like inanimate objects) but a group of individuals that had a high level of expertise in many, many different organ systems, and therefore represented the final authority on a very difficult case. So the soft-tissue department became a reference center, if you will, for very difficult soft tissue lesions, or tumors. Malignant soft tissue tumors, are so incredibly rare that there were very few people in the entire country that could even approach the level of expertise. No individual pathologist could ever see the number of cases that this referral center received. In effect, the AFIP had an unnatural advantage. It had the largest repository (and probably still does have) of soft tissue lesion anyplace in the world. So it was a wonderful opportunity to acquire expertise very rapidly.

Yo give you an example, there are about 4,500 malignancies of soft tissues that are reported every year in the United States. The soft-tissue department, when I left, was seeing approximately 4,800 cases, of which half of those were probably malignant. So you can see what percentage of all of these tumors in the country people at the AFIP might be seeing.

The referral patterns have now changed. There are so many good consultants in the country that the AFIP does not really have that market cornered, but back in the fifties and sixties it certainly did.

Q: All right, you've got this vast collection, and here you are, you have come from Johns Hopkins, which only has one small thing. What you're saying is, most doctors don't see all these things. Now how do you, within a relatively short time, begin to acquire what amounts to a big data bank of knowledge of what these things look like? Did you find that it was relatively easy to go to, essentially, the files to get examples? How did you build up your own expertise?

DR. WEISS: There are two ways. First of all, the cases come in on an ongoing basis. So every day, for instance, there might be ten new cases, twenty new cases, which you would look at and try and arrive at some sort of diagnosis.

At that time I arrived, Dr. Franz Enzinger was chairman of the branch. Dr.

Enzinger had more experience than anyone else. He was, I would say, a self-made pathologist, in the sense that he did not have a mentor. He simply had the material, time, drive and energy. He really taught himself about tissue pathology. He had, of course, this phenomenal advantage of the case material. So when I arrived, I had a superlative diagnostician going over cases with me. Basically, you would look at it, you would make a diagnosis, but then you would have someone saying, "Well, I don't think that's right," or "I think it's more likely this or that." That certainly gives you another enormous advantage. And so in an environment like that, you can become very good very fast, and in two or three years you have seen more than anyone else in the country. Thus, young people out of their residency, at thirty-two or thirty-three years may have seen more than some senior pathologists at the best universities.

Q: Yes, this is the force-feeding if you're at the acme. I think you've been telling me, but I wonder if you could describe it, what was the atmosphere within the soft-tissue branch? Collegial? Competitive? Fun?

DR. WEISS: Well, it was a very small department. "Department" is really too impressive a word for these little collections of people. We were three people: there was Dr. Enzinger, myself, and a young Air Force pathologist, Dean Lauier. That was the soft-tissue department, really a small family. Departments at that time were sometimes referred to as fiefdoms. There was sort of a feudalistic arrangement of these little fiefdoms. Departments were very small. For the most part, people got along. But, I tell you, if things didn't go well, it was terrible. If one person was having problems getting along with a second person in a small department, that could represent two-thirds of a department. So it was to everyone's advantage to get along well. Our department was a relatively happy department in the early years. There were a lot of things that happened externally to departments that created frictions and problems. But I can certainly say that there was a very collegial atmosphere in the early days. I never felt there was a competitive atmosphere within departments but often between departments. But I guess that happens in university hospital departments. And there are always issues of allocation of space and personnel.

Q: I would think that in your branch particularly, when things would come in, you would be called upon to respond rather quickly.

DR. WEISS: One would think that. But there it was a pecular very leisurely attitude about the handling of cases at the AFIP. I think partly because we considered ourselves tertiary, or even quaternary, consultants. We were not the docs on the front line. We were not the pathologists dealing with the surgeons, so we were removed. Secondly, although there is now a charge system in place for cases, there was no charge system then. There was a "I'm-doing-you-a-favor" sort of attitude. Within certain departments there was a sense of urgency. In other departments reports would be issued months after the fact. There were one department, which shall go nameless, in which there were cases that

were sitting around for years!

Q: Well, I remember reading something saying this is a military organization and these things should come in and go out. Besides the fact you might be reading, although it would be good for future pathologists, the patient might have long been buried.

DR. WEISS: That's right. Well, I think those of us who were young and who had just come from hospital settings did have a sense of urgency. For instance, I'm at the University of Michigan Hospital now. We turn our cases around in forty-eight hours. You cannot not have an outstanding report on a patient oryou'd start getting phone calls from surgeons. So I think those of us who had recently been at a university hospital, or at a hospital, had a sense of urgency about what we were doing.

The longer one stayed at the AFIP, the more removed one was from really how medicine was practiced on a daily basis. Some of the senior AFIP pathologists who had really never practiced medicine in a hospital setting, didn't quite understand what was expected of them. And as a result, I think the AFIP for many years had a reputation of just being very slow and sluggish with turning cases around. There were of course exceptions; there were some departments that were always very timely.

But I think that is now dramatically changing, with this fee for service that is in place, because people expect service when they pay. Whether it's a consultation, or whether it's having a watch fixed, or whether it's someone mowing your lawn, you pay money, you expect a certain amount of service. And that's good. I think it's good that the AFIP has had to adopt an attitude and a posture more like the rest of medicine.

Q: Well, I've heard it said that one reason why they adopted this posture was that at one point they were getting things referred to them because the doctors on the line generally wanted a reading from experts, but later it began to be a CYA, a sort of a cover-your-ass type proposition, from looking towards malpractice things, and so people were sending these in just routinely and clogging the system because they wanted to say, well we did send it to the AFIP. Did you have that? You were there during the period when all of a sudden malpractice became a major thing. Did you get a feeling about that?

DR. WEISS: Oh, yes. There were certain contributors who would routinely send us any case that was at all difficult. When they hit a bump in the road, the case would go off to the AFIP. Certainly, that occurred.

But I thought what you were going to start to say was, Did we start handling cases faster because we had to CYA, too? And I think we did. I think the litigious era affected not only people's referral patterns to us but our behavior toward them. Even though we weren't charging for a case, how could you justify delaying a diagnosis of a malignancy three months on a patient? Suppose a contributor sent you a case he thought was benign, and you waited three months, and then you said, oh, no, it's malignant. Well, this would be terrible; the patient might have had therapy delayed for three months. So I think there was a greater sense of medical and ethical responsibility on our part.

Q: Did you feel this coming at you? And did you feel the difference between, you might say, the medical side and the military side, from the top, on getting things out, moving things along?

DR. WEISS: Well, paradoxically, I often thought that the sense of urgency about cases came from the military directorate. They had a keener sense of what we ought to be doing as far as turning cases around rapidly than some of the senior doctors. And I think it goes back to the fact that many of the senior doctors and chairmen of departments had never recently been in a hospital situation, whereas our directors had all been directors of military hospitals. And so I give them credit for leaning on people.

In fact, I remember, in the mid-eighties, the directors quite frankly said that if some departments had cases that were more than ninety days old, the individuals in the departments would be denied administrative absence; they could not go off to that nice international meeting that they wanted to. I actually know of an instance where the director stopped a chairman at the door and said, "Unh, unh, unh, unh, unh. Not so fast. You've got a few cases to finish up." I thought that was wonderful. We often tiptoed around the chairmen, and here was a director who simply said this was unacceptable behavior. Go back and finish your cases.

Q: It does remind me of a university situation where you've got the administrative dean dealing with a professor with tenure who may need some shaking up sometimes.

DR. WEISS: That's right. You deal with full professors with tenure sort of gingerly. I thought it took a lot of guts on the part of the director, and I was one of the cheerleaders on the side.

Q: I don't want to overdwell on this, but you were in a military institution, with these doctors did you find that it was sort of a men's club, or was this pretty much you were all doctors together?

DR. WEISS: I think it changed while I was there. I think when I was first there it an elderly men's club. It was also a military club.

But toward the end of my tenure at the AFIP, things changed. During the tenure of Col. Thomas Zuck things began to change. He wanted to see some changes, and he didn't necessarily feel that everyone who voiced opinions and who brought forward ideas had to be one of the chairmen. He would go around and solicit opinions from the young staff there. His tack was to sit with a different person at lunch every day, to find out what was really going on. He raised the level of consciousness about what had to be done at the AFIP, in the younger staff. That period was sometimes referred to as the "Palace Revolt" period. That was when changes began, and the balance of power began to shift. Whereas formerly it resided almost exclusively with the chairmen, we began to hear more from the assistant chairmen and from some of the junior people who were in the

department. That was an important turning point.

Q: This was about when?

DR. WEISS: Tom left, I think, in 1984, after having been at the AFIP only a couple of years. He left to take over Letterman Army Institute of Research. Tom was a very bright person; he was a Yale-educated lawyer, articulate, aggressive, and extroverted who saw the need for change. So I think whereas it may have started off, as you described it, as a club, or a clique, it changed. By the time I left, I think things had dramatically changed. At the time I left, I was the chairman of the soft-tissue department, and we had a few other women chairmen. We also had a woman associate chairperson, Dr. Mullick. Committees were formed with more input from junior staff. You asked me earlier about how we selected people to come to work there and I said, "Darned if I know." By the time I left there was a search committee, with a more democratic process in place. Perhaps it simply reflected what was going on in other institutions as well. So I witnessed very positive changes in how things were arranged administratively, and how the Institute came to reach a consensus on issues. In fact, there was more of a dialogue among members throughout the Institute than dialogue among the very top.

Q: In your particular field, obviously what you were getting was coming from all over, did you feel any pressure or concern to try to make it as pertinent to the military as possible--for funding, for support, and the fact that you were the Armed Forces Institute of Pathology?

DR. WEISS: Yes, there was always this undercurrent of military relevance. At the end of every research proposal, you would have to state military relevance. Quite frankly, much of what we did was no more relevant to the military than it was to the civilian. Or, conversely, it was just as relevant to the military as it was to the civilian. So I always found that a little bit strange, this emphasis. I mean, I understood it; if the Department of Defense is picking up the tab, surely they want to know what they're buying. Is it going to help them directly, or is it a very peripheral thing? Whether they got their money's worth, I don't know.

It's often been argued that the AFIP should have been put under Health and Human Services, that it fell more appropriately under the civilian scientific than the military sector. But it had its tradition: it began as the Army Medical Museum and it did serve a very important QAQC (quality,assurance/quality control) function, for military hospitals. So its beginning defined its allegiance, or its ties, to the Department of Defense. As things have evolved, one could make a good case for having it moved to another federal agency.

Q: Well, did you sort of have a folder which showed how many soft-tissue problems there were in the military, and you could put these in and say fifteen percent of the military at any one time have this, and obviously we have to be able to deal with these, give it that

military focus, although it represented the rest of the population, too?
DR. WEISS: Well, I don't know if we had data as detailed as what you're citing. We would say a certain percentage of our cases came from the military, a certain percentage of them were malignant tumors, therefore the military had the same problem as the general population. But that's sort of restating the obvious. I mean, unless you're talking about peculiar environmental exposures--Agent Orange and that sort of thing--there's no reason to expect that the distribution of these lesions is going to be different in military group than your civilian group, particularly since what we were seeing originally represented military families, not just the military officer himself.

Q: And also veterans, too.

DR. WEISS: And veterans, too. Now that may be changing. I don't know to what extent we now see materials from the families of Army officers, but certainly back in the fifties and sixties, and even when I started, you would see a good cross-section of material based on officers and enlisted men and their families. But now, that emphasis is changing in military hospitals. Some military hospitals, I understand, don't have certain types of departments anymore. Their families may be cared for in civilian facilities. It may be that, as I said before, they are just as represented. With these particular lesions at the civilian center, that may not be true, because of our selectivity now and what military material may be seen.

Q: Obviously, you were sort of like a supreme court on these things that would be coming in to you. Did you get any impression from doing this, over the time, about the competence, strengths, and weaknesses of, say, universities, military hospitals, or what have you, as far as how they were calling the shots?

DR. WEISS: Well, I suppose, at the large military hospitals, the teaching hospitals--Walter Reed, Madigan, the Naval Hospital--that there was a high level of competence, because they had teaching programs, and experienced pathologists (at least they used to). At community hospitals, it was highly variable. The university hospital traditionally did not refer cases to the AFIP. For instance, it would be very unusual to see a case referred from the Harvard Medical School or from Yale or from Stanford. That's not to say we didn't see them. In the Soft Tissue Branch, we did see them, but they would be sent to me personally. It would be a personal letter to me from a professor at Stanford to look at a case. I don't think we ever really functioned across-the-board as a referral center for university hospitals. University hospitals are very good; they're not apt to need our expertise.

And one thing that may not be cited quite a bit by people at the AFIP, but there were marked differences in expertise between most departments at the AFIP. There were some departments that had a very strong reputation and would get numerous referrals; there were other departments that had maybe just an average reputation; and even a few that had a poor reputation.

Q: Now you're out of the business, and obviously these things change, but where was sort of the reputation or the strengths and weaknesses of the AFIP with the departments?

DR. WEISS: The strong departments generally followed the strong chairmen. For instance, I think unquestionably the soft-tissue department was considered one of the strongest departments. If you also consider impact factor, not just diagnostically a good department, but the impact it had on the outside, I think probably the soft-tissue department had the most impact of any department, because it had cornered the market in that area to a greater extent than any other department had.

The GYN department, headed by Dr. Norris, was also a very excellent department, but at the same time there were a number of excellent consultants throughout the country, so I think the market was less cornered there.

Dr. Mostofi had an international reputation, and much material was referred to the GU department.

Dr. Ishak was considered one of the premier liver pathologists. Although there were not a lot of cases referred to the liver department, clearly he had the reputation. I mean, he would be a person that would get a case from a university hospital, unquestionably. Dr. Ishak has seen more unusual liver tumors than anyone else. Just as these individuals drew consultations, so, too, would their retirements, or departures be accompanied by a significant loss of prestige and consultations.

I hope I'm not missing a department that's very obvious. I would feel very bad.

Q: Well, you can also add on to this.

DR. WEISS: Right. So those departments really were premier departments and, therefore, served a very important role in the consultation activity in the country.

Q: You were mentioning Agent Orange. I might just say, for the record, because this may be a case that's lost to historians unless they look it up, that it was a defoliant used in Vietnam--very effectively. I served in Vietnam for eighteen months, and so I saw where it really knocked down the underbrush. It was designed to keep the insurgent forces from having cover when they went after our troops. But later it became quite a political case because of what it was purportedly doing to our troops, and the government was denying it because of suits and all that, and it got mixed up in politics. This must have been a very tricky thing because of the political and financial impact this had on the government, but it fell right in your bailiwick, didn't it?

DR. WEISS: Yes, it did. We certainly would see cases. Any tumor that occurred in a veteran of Vietnam would be referred in. We had many VA claims cases, so that eventually we established a registry at the AFIP, the so-called Agent Orange Registry. Any person, allegedly exposed to Agent Orange whosubsequently developed a biopsied lesion, would have it referred to the registry. These were very tricky cases. There still is

no clear-cut evidence linking Agent Orange to sarcomas; there is circumstantial evidence, but there's not strong evidence based on the data that came out Vietnam. My own personal belief is that it may well be related. That is dioxin in high levels may well cause tumors, specifically sarcomas, in patients. There was never any evidence that it happened in the Vietnam group, but some evidence that it may happen in industrial exposures, where the levels are higher and more prolonged. The final verdict is not out on Agent Orange. But, of course, as you know, there was a class-action suit that was settled back in, I guess, 1984. The Vietnam veterans got about a hundred and eighty million dollars.

Q: Did you feel any pressure to lay off this, or watch this?

DR. WEISS: Well, we were told to be very cautious in what we wrote on any veteran's claims relating to tumors. I never wrote a VA claims' case alleging a connection between the tumor of a Vietnam veteran and Agent Orange. No one could really write that outright, because there wasn't any data. But we would see numerous benign tumors, in veterans that had been exposed. It's very difficult in an individual case to pin it down and say yes or no. I do remember writing a report on a patient who had developed a malignant tumor, stating that his experience of serving in the military may have exacerbated the condition, not that it caused the condition. I do remember writing that, but we were told to be very cautious in what we wrote. I suspect that what we wrote probably even went through the legal department there, just to make sure that the verbiage was correct. Those were very difficult cases to do. They often came with charts that were eighteen inches high, and you had to go through it and reconstruct the history and then look at the slides and then answer a rather specific set of questions in a very precise fashion.

Q: What about ones from the nuclear testing, did you get involved in that?

DR. WEISS: No, I never saw any of that material. I understand some of the Hiroshima/Nagasaki material resides at the AFIP.

Q: Also from Operation Crossroads. This was where we very casually put our troops in there to look at things the day after a nuclear test.

DR. WEISS: No, I never saw that; I would have liked to have seen it.

We did see material on famous people that was kept in a special file down in the basement, in the archives of the AFIP, that was locked and only people who had a need-to-know clearance could get into it.

I was asked to sign out President Reagan's hand tumor when I was at the AFIP. He was operated on at Walter Reed, and then his slides were sent to me. I was chairman of the soft-tissue department at the time, and so I had the opportunity to diagnose what his hand tumor was. It was always very nerve-wracking to handle famous people's cases, because, you know, the old adage is that if it's someone famous, something is apt to go

wrong. You will lose a slide, or a block, or tworse yet they'll have a borderline tumor that you can't really decide what it was. Fortunately, President Reagan had a very straightforward case, as far as I was concerned. But he had the most enormous pile of slides. You know, he of course had colon cancer two years before he had this hand tumor, so all his colon cancer slides were sectioned. I mean, he has the best-sampled colon cancer of anyone in the country, and descriptions of this colon cancer like you've never seen. We would never write descriptions of anyone's colon cancer in our own hospital as was done for the one President Reagan had. But I guess rank has certain privileges.

Q: Talking about these hospitals, this was Walter Reed, but some of the top-ranking people go to Bethesda. Did you find yourself in competition with Bethesda or not?

DR. WEISS: We didn't really have that sense of competition, because we didn't feel that close to Walter Reed. We were a referral agency for the military; Walter Reed simply happened to be on the same campus. My father had been chief of general surgery at Walter Reed for many years, so I knew Walter Reed very well. I don't think we felt it, certainly not the civilians.

Possibly the military felt the competition. I do remember a story from the Kennedy era. This was, of course, before my tenure at the AFIP. My father, during the Kennedy era, had been at Walter Reed. When Jackie Kennedy got pregnant for the second time, everyone expected she would deliver her baby at Walter Reed. Rumor had it that the suite where she would have been housed, and where Mamie Eisenhower had been housed previously, was repainted. It was repainted from "Mamie pink", a shade of pink that Mamie Eisenhower liked, to sort of an eggshell color, which was Jackie's color. So they were prepared for Jackie to arrive any day and have her baby. She snubbed them by checking into Bethesda Naval Hospital and having her baby there. And Walter Reed was quite offended by this.

Q: You arrived just at the very end of the Vietnam era, but you saw the development. The military had taken a terrible pounding, moralewise, and the draft was over and everything else, including the draft of doctors. Was there a feeling that the AFIP was also getting reflections of this, and was it sort of regrouping?

DR. WEISS: Well, the one tangible fall-out of the change in the military climate for the AFIP was that the draft of the doctors was over and the Berry Plan was in its final stages.

Q: The Berry Plan being...?

DR. WEISS: A plan during the doctor draft period whereby a doctor could defer his military obligation to an agreed upon date. The Berry Plan became a very important source of highly talented academic pathologists for the military. Here were people that otherwise would have been in their training program at Columbia Presbyterian or

Stanford, but now had to spend two years in the military. And of course where did they want to go if they were academically oriented? Well, not to a small military hospital; they wanted to go to the AFIP. So in the early seventies, there was this constant source of Berry Planners. Dr. Dehnei, who's now the professor and director of anatomic pathology at Barnes, had been a Berry Planner at the AFIP. Dr. John Fenoglio, who wrote the cardiovascular fascicle, had been a Berry Planner at the AFIP. I think maybe Michael Koss, who's now the chairman of the pulmonary department at the AFIP, had been a Berry Planner back in his days. There were a lot of very fine pathologists in that program.

When the Berry Plan ended that source of talented, academically-oriented pathologists stopped, and then we went through a period during which it was hard to find people. We were almost soliciting individuals, and taking foreign-trained people. I don't mean that to sound negative, but often-times the people we were taking were not well trained. There was a deterioration in the quality of military pathologists coming to the AFIP.

Q: In talking about the various people, do any of the directors or deputy directors of the AFIP in the period you were there stand out in your mind?

DR. WEISS: Well, I came when Jim Hansen was just finishing, and I was probably there two weeks when he left, so I don't have any recollection except he wouldn't give me a parking place.

Q: Well, this, in any organization, is usually a major perk.

DR. WEISS: The next director was Elgin Cowart. Elgin was a nice person, I always liked Elgin. The director after Elgin was [William R.] Cowan, and Cowan was sort of an easy-going Southerner. I suppose I would have to say that both of them perpetuated the status quo; there were no great changes made.

When Dr. [Robert R.] McMeekin came onboard, he was viewed the wunderkind: he was young and endowed with both a MD and JD. He had some good ideas about what he wanted to do. I never understood why he didn't stay longer. I was told there were a lot of politics involved. His tenure was sort of cut short. He was the first director I would go and talk to if I had a problem. He was closer to me in age than the others. I really thought he was a man that, deep in his heart, really wanted to change things. He wanted to be remembered for doing things. It that was very sad when he left. I think he was very disappointed. I know his wife was almost tearful at the change-of-command ceremony.

Bob Karnei I knew the best as director. He came from the Naval Hospital. Bob was a very good-hearted person, but he had a way of acting that would make things worse after he had interceded. Oh, there were a couple of things that I remember happening. But Bob was the person I meant when I talked about directors who had been head of military hospitals having a keen sense of the patient and wanting cases. Bob was the first one that really started saying, "Look, there's a patient here, let's get this job done". I mean, he would bulldog you on cases, I remember that about him. I left during Bob's

tenure.

I mentioned Tom Zuck earlier. Tom had never been a director. He had been associate director, but he acted like a director. Tom had the mettle. Had he been allowed to stay (and I think there was some politics surrounding that), he would have gotten to be director. And who knows? It might have been different.

Just recently the directorship changed again--Vernon Armbrustmacher. Vern was actually a very close friend of mine. Vern and I came to the AFIP almost the same time, we're very close in age, and we sort of moved up the ranks simultaneously. Vern is a very reflective, intelligent person with impressive credentials as an academic pathologist.

You have to understand that there is a strange dichotomy here. You would have a civilian staff that was very good and well-recognized in their particular areas, but then you would pick the director from a group of hospital-based military commanders. And you would put that person incharge of a talented group of civilian pathologists. At times there would be even an antagonism. So Vern is the first person that I think has credentials to the extent that he can talk to the pathologists in the Institute at the same level. All of these others had entirely different backgrounds, and, as I said, they're selected with a different set of criteria than we select a chairman.

I just never knew the other directors. I saw Dr. Ash when he came to give the Ash Lecture. He was about ninety-nine years old when he came.

We used to have a joke at the AFIP. Someone in our department made it up. Because the average age at the AFIP was exceeded only by that of the Supreme Court, we postulated that once one had been at the AFIP for ten years, that that conferred immortality on one, because we had never met anyone that had been at the AFIP for ten years or longer that had actually died!

Q: Yes, I'm discovering that. I'm talking to men well into their seventies or eighties now, and they're fully active. Obviously, pathologists don't die, and they keep working.

DR. WEISS: Well, when Dr. Ash died, that shot the theory, but up until Dr. Ash's death, our theory was a hundred percent.

Q: Well, tell me, two branches of the work that was being done there, the museum and training. Did the museum play any part in your work at all?

DR. WEISS: No, not really. It was something else. I didn't have a keen sense of what was going on in the museum. They built that very nice museum, that was very lovely, but as far as the everyday workings and what they intended, I did not have a clear sense of what was transpiring.

Q: How about the training? There has always been this training program with people coming in. Did you get involved much in that?

DR. WEISS: Yes, we had a constant retinue of people from the United States as well as

people from other countries that would come for various periods of time. That's what you're referring to, I take it?

Q: Yes.

DR. WEISS: At times it was good, at times it was bad. It's nice to see people from different countries, and I had some really wonderful experiences with a doctor from China who spent a year with us. But there were other times when we would have sometimes three and four people from other countries in our department at the same time, and it would almost be like a Tower of Babel. You'd be sitting there at sign-out, and there would be all these questions, obtuse questions, and you wouldn't know how to answer them. It would really slow you down. And I suppose some of it had to do with my own impatience. If I was very preoccupied, I wanted to finish the sign-outs, I just didn't feel like I was in a teaching mood, and this would be sort of irritating. But then there would be times when, if you felt more relaxed and you didn't have a lot of cases, you could talk to these people, you could really feel like you were giving them a lot. But, unfortunately, during the period that I was at the AFIP, the caseload was enormous. It was staggering at times.

The problem with the AFIP was it did not have continuity and stability in departments. It would have one person at the top that was good, and, if you were lucky, a second person. Everyone else changed every three years. It didn't matter if you had six people in your department if only one person was able to sign out the tough cases and they all came across your desk. There would be some days when I would have fifty or sixty incredibly difficult cases to sign out. It would be just mentally sapping to have to go through these. And to add to it the burden (and it was a burden) of having a foreign doctor sitting across from you asking you questions on every case... I mean, it could go on for a whole day; you could order pizza out that evening. So, as I said, there were some good things and there were some bad things. And I often told Dr. Enzinger that I didn't think we should have more than one person at a time in the department, that having two and three people was just too many. But I guess some departments felt that it was an obligation that we do this.

Then, toward the end of my sojourn there, they started to charge. They charged the individuals that came from other countries for their training a fee. I think eighty dollars a week was what was levied for the opportunity to come and sit-in on sign-outs.

We also had residents from our own training programs in this country. My feeling about that was I really didn't think we should have them unless they were very keen. In other words, it would be all right to take someone in their last year of training, but because we were so superspecialized, I couldn't see the value of having junior residents, and I certainly didn't think it was appropriate to have medical students.

Q: It does seem like a waste.

DR. WEISS: It was a waste. I also got the feeling that there were hospitals in the

Washington area that really didn't want to take time training their own residents. They sent the residents to the AFIP--"Oh, send them over there." I think that's abdicating your responsibility. These are your residents, you have these four years during which you can formulate the way they think, you can train them. To farm them out was wrong.

Q: Looking back now on this, where do you feel you made your personal greatest accomplishment that gives you satisfaction? And the reverse side, what was sort of the biggest disappointment?

DR. WEISS: Well, I think my greatest accomplishment, or what I feel best about, was publishing our textbook on soft-tissue tumors. That represented the culmination of probably a couple of decades of Dr. Enzinger's experience and several years of very, very intense writing and studying on my part. We were very perfectionistic about it. And when it was finished, I felt it was almost like giving birth to a child; it was such a labor. I was very pleased, and we received many kind compliments from our colleagues, people that I really truly respected. I think the respect and the praise of my colleagues concerning the book really made me feel good about that time that I had spent.

It goes without saying that the AFIP, by virtue of the fact it had this unique referral pattern, a large number of patients, and the fact that as a junior faculty or a junior staff there you were allowed to pursue something in a really very focused fashion (I had no administrative responsibilities when I was a junior faculty there; I had really no teaching responsibilities; I didn't have to worry about tenure) there were a lot of things that were good about the AFIP. I would not have been able to do that, or it would have taken me a lot, lot longer, at a university hospital. It would have been something I would probably be able to do when I turned sixty or sixty-five. I started writing the book when I was about thirty-one or thirty-two, and it was published when I turned thirty-seven. So I considered that an accelerated time course for something like that.

Disappointments. It's a difficult question. I think probably what disappointed me the most, and I saw this happening in a number of areas in the Institute, was the inability of chairmen to really nurture the careers of those under them. I think the AFIP was a place that encouraged (I hate to use this word) "prima donnaism." There was room at the top for one person, and that was the chairman of the department. And that person got all of the attention and all of the glory. And sometimes what would happen in departments is the chairperson would just use that position for his or her self-aggrandizement, without seeing beyond the short-term future. One's real self-aggrandizement is in whom you train and who carries on your name after you. That's the long-term future. And I think many chairmen did not see it that way; they had only a short-term view of things. Those chairmen that had a long-term vision (but they were rare) and could see the perpetuation of their ideas in pathology and the training of people as a noble goal had successful departments. The rest simply used junior staff and, did not reward them appropriately. Junior staff left regularly. That was bad. And I think that some of these directors that I've talked about, for instance, Dr. McMeekin and Dr. Armbrustmacher, saw that, too, and tried to rectify that. I hope it will change.

Q: Well, talking about leaving, you left in 1989. What spurred you to leave after this thirteen-year stint?

DR. WEISS: Well, I think I began to say to myself, "Is all there is? There has to be more than just this." I didn't feel that coming to work every day and sitting at a desk and looking at soft tissue cases all day in a repetitive fashion, was going to keep me happy for the rest of my life. To be a complete pathologist, you had to interact with clinicians. You have to know some basic science and interact with basic scientists. You have to appreciate the welfare of patients. You have to understand something about medicine in general and the utilization of resources.

And then I saw the era of molecular biology arrive, and I just didn't think the AFIP was going to be able to implement that technology fast enough and in a way that it would really be on the cutting edge of pathology. Now I may be entirely wrong.

But I think the university hospital has an edge, because they're near the patient, get immediate follow-up, we have access to fresh tissue, which is needed for many of these ancillary techniques, and we are able to keep a retinue of people in different disciplines.

One of the greatest pleasures now that I have in my new job is that I go to a multidisciplinary sarcoma conference every month, where we have a radiotherapist, surgeon, radiologist, and oncologist. We take the most difficult cases and discuss them together.

That's something that you cannot have at the AFIP, just because of the way it's set up. It's not a hospital.

I also think residents are very important. Residents keep asking you questions, and by virtue of their questions, it keeps you on your toes.

And so I felt the AFIP was an excellent place to go and learn something well and get good very fast and write your book or whatever it is you have to do, but that, ultimately, to be completely fulfilled as a pathologist and a physician, you would have to return to a university hospital.

I guess, in a way, I always knew this in the back of my mind. And after thirteen years, at the age of forty-four years, I said, "If I want to do it, it has to be now, or else I'll be too old.

Q: So you left to go where, to the University of Michigan?

DR. WEISS: I'm at the University of Michigan where I am director of anatomic pathology, chief of surgical pathology and a professor of pathology. It's nice because I run my own shop. I direct a division of about twenty-five pathologists. We have twenty-seven residents, and I'm able to plan, in part, their program. I sign-out general surgical pathology, but have a very large private practice in soft-tissue pathology. I acutally see more soft tissue cases than when I was at the AFIP! So I feel I have the best of all possible worlds. I also only have a six-minute commute, compared to my daily hundred mile commute to the AFIP from Baltimore.

Q: Well, I want to thank you very much.

DR. WEISS: Oh, well, thank you, Mr. Kennedy, it's been very pleasurable.

Q: This has been fun.